Prevention and Early Intervention Project

Subcommittee Meeting Summary

October 11, 2019 | Salinas, CA (Monterey County)

Meeting Purpose

This document summarizes the second meeting of the Mental Health Services Oversight and Accountability Commission's Prevention and Early Intervention Subcommittee. The first meeting was held in Sacramento to introduce the project and identify areas of need for prevention and early intervention. The Subcommittee is holding a series of meetings to engage community members and other stakeholders to explore challenges and opportunities to prevention and early intervention.

The second meeting of the Prevention and Early Intervention Subcommittee was held in Salinas in Monterey County to explore opportunities for using data and evaluation to improve outcomes, and to generate information to guide local and state progress in prevention and early intervention. The presentations and group discussion are summarized below. The Prevention and Early Intervention Subcommittee will next host an event in Southern California in early 2020.

Discussion Overview

The meeting opened with a panel of speakers representing organizations involved in prevention and early intervention efforts to talk about challenges and opportunities for measuring and tracking outcomes. Presenters included a representative from the Monterey County Behavioral Health Department and representatives from local prevention and early intervention programs operated by Interim, Inc. and the Epicenter of Monterey County.[1]

The presentations highlighted challenges to evaluating prevention and early intervention programs. For example, Interim Inc. representatives identified a lack of linguistically appropriate staff as one of the challenges, which makes it difficult to collect information from specific populations. Another challenge to evaluation identified during the presentations was survey fatigue, which is a common problem that can lower the quality of data obtained.[2] However, speakers recognized that incentivizing survey completion was helpful for increasing participation.

A representative from the Monterey County Behavioral Health Department shared her data collection strategy and key program benefits, which include increased coping skills, cultural competency, and overall well-being. A person with lived experience attributed her ability to thrive to the support of friends, family, and community. One presenter emphasized the

importance of individualized care, and that youth and young adults should not have to navigate the mental health system alone.

A facilitated discussion followed the presentations. Meeting participants identified challenges to monitoring prevention and early intervention program progress, as well as the different ways success is demonstrated. These topics are discussed below.

Barriers to Improving Services and Outcomes

Meeting participants identified several barriers to improving prevention and early intervention services and outcomes. These barriers are summarized below.

Limited Program and Evaluation Flexibility Meeting participants identified barriers that may limit evaluation and reporting flexibility. For example, current regulations require reporting only of the unduplicated number of people served by a prevention and early intervention program.[3] It is, therefore, not possible to demonstrate using these data how people who frequent a program are benefitting from its services. Meeting participants discussed how this is important in tracking positive outcomes that may be associated with repeat access and utilization of services.

Meeting participants also identified definitions of demographic categories that may result in inaccurate descriptions of race/ethnicity, sexual orientation, and gender identity of people served because the categories defined by law may not reflect how a person identifies. Lastly, one meeting participant noted that current regulations limit the amount of time a person can be served under certain conditions, making it difficult to track long-term outcomes and deliver relapse-prevention services. For example, early intervention programs, as defined by regulations, limits services to 18 months unless a person is exhibiting psychotic symptoms.[4]

Limited Cultural Relevancy Meeting participants highlighted the need for delivered services to be relevant to the culture being served. One meeting participant commented specifically on peer-led services and stated that providers must be relatable in both culture and language to the people they are serving. Another meeting participant agreed and added that even if a program has demonstrated success with one group, that success may not translate to another group if the services are not culturally relevant.

One meeting attendee highlighted the disparities in service access, utilization, and outcomes created as a result of minority stressors and intersecting identities of people served. Minority stressors are experiences of conflict between minority and dominant cultures in society that may contribute to poor mental health outcomes.[5] In addition to minority stressors, meeting participants also discussed other life stressors that may present barriers to successful program participation and outcomes, such as a lack of childcare and transportation, as well as possible traumatic social and political climate.

Inherent Challenges to Measuring Success Meeting participants identified several inherent challenges to measuring successful prevention programs. One meeting participant stated that the success of prevention services has more to do with the relationship created and maintained between the person and the provider than the characteristics of the service. The data currently collected do not measure this as a factor in demonstrating outcomes. Another meeting participant suggested increased collection of qualitative data to describe program attributes, including the type of providers delivering services. Provider attributes could include type of lived experience and level of cultural and linguistic relevancy.

Another challenge inherent to prevention efforts in general is capturing data to describe the prevention of a particular outcome since, by its definition, the outcome has not occurred. For example, it is not possible to measure the number of people prevented from dying by suicide or becoming incarcerated as a result of their mental health need because of the prevention and early intervention services received.

Meeting participants noted the need for more primary prevention services but discussed how these types of services are difficult to measure and, therefore, positive impacts are often unknown.[6] Lastly, it was stated by a meeting participant that thriving with a mental health need is possible, but what this looks like should be determined by the person, as it may appear differently from person to person.

Approaches to Overcome Barriers

Below is a summary of approaches discussed by meeting participants to overcome barriers to delivering and evaluating prevention and early intervention services.

Serve the Whole Person Several people with lived experience who participated in the discussion identified components of successful programs. They attributed their own personal triumphs to supports beyond mental health impacting other areas of life, such as school, home, church, and the community.

Use Standardized Metrics Meeting attendees highlighted the opportunity to scale-up prevention and early intervention services by having standardized metrics for evaluation. One benefit suggested by a meeting attendee was that the State could focus its technical assistance resources to building infrastructure and guidance for collecting and reporting data. The Measurement, Outcomes, and Quality Assessment (MOQA) initiative was one example of a statewide effort to standardize measures to increase the delivery of successful programs.[7] Attendees suggested that metrics should shift away from deficit-based outcomes and focus on measures of resiliency. These standardized metrics should be established in addition to descriptions of real-life stories of people being served.

Collaborate to Expand Resources and Information Meeting participants highlighted the prevention and early intervention opportunity at an early age and gave examples of existing

public health programs and initiatives to support at-risk families and youth. Existing resources and relationships could be leveraged to increase services to young children, parents, and families. Meeting participants reiterated the importance of flexibility to allow for blended funding and opportunities for enhancing programs through collaborative resources and relationships; otherwise, strict program and reporting requirements hinder opportunities to integrate funds and share data.

Next Steps

An event in Southern California in early 2020 is being planned, and information on that event will be released soon. For more information, including upcoming events, please visit the project webpage at https://mhsoac.ca.gov/what-we-do/projects/prevention-and-early-intervention.

About the Project

California's Mental Health Services Act (MHSA) was enacted by voters to transform the State's mental health system. The act dedicated funds for prevention and early intervention as well as innovation to better meet the needs of Californians. Each year, California dedicates some $400 million to approaches that prevention and early intervention by reducing risks and supporting protective factors.[8] Senate Bill 1004 (Chapter 843, Statutes of 2018) directs the Commission to establish priorities and a statewide strategy for prevention and early intervention services. In response, the Commission formed its Prevention and Early Intervention Project to create a more focused approach to delivering effective prevention and early intervention services and to increase coordination and collaboration across communities and mental healthcare systems.

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[1] Visit https://www.interiminc.org/ and https://epicentermonterey.org/ for more information.
[2] O'Reilly-Shah, V. N. (2017). Factors influencing healthcare provider respondent fatigue answering a globally administered in-app survey. *PeerJ, 5:e3785.* doi:10.7717/peerj.3785.
[3] Mental Health Services Oversight and Accountability Commission. Prevention and Early Intervention Regulations, amended July 2018.
[4] Ibid.
[5] Dentato, M.P. (2012). The minority stress perspective. American Psychological Association. Retrieved on October 22, 2019 from https://www.apa.org/pi/aids/resources/exchange/2012/04/minority-stress.
[6] Australian Government Department of Health (2014). Challenges of measuring outcomes for suicide prevention. Retrieved on October 23, 2019 from https://www1.health.gov.au/internet/publications/publishing.nsf/Content/suicide-prevention-activities-evaluation~findings-effectiveness~challenges-of-measuring.
[7] California Institute for Behavioral Health Solutions. Measurements, Outcomes, and Quality Assessment (MOQA). Retrieved on October 23, 2019 from https://www.cibhs.org/measurements-outcomes-and-quality-assessment-moqa.
[8] Department of Health Care Services (2019). *Mental Health Services Act Expenditure Report – Governor's Budget Fiscal Year 2019-20*.